AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALER

WILLIAMSBURG ELEMENTARY SCHOOL

839 SPRING STREET WILLIAMSBURG, OHIO 45176
PHONE 513-724-2211 FAX 513-724-3902

STUDENT NAME: ______________________________ DOB: ______________
DATE: ____
ADDRESS: ____

AUTHORIZATION IS HEREBY GIVEN FOR THE STUDENT NAMED ABOVE TO:
[ ] receive the prescribed medication indicated from the designated school personnel.
[ ] self-administer the prescribed medication as permitted by law.

Medication Name: ____

Dosage: ____

Date the administration is to begin: ____

Date the administration is to cease: ____

Adverse reaction that should be reported to physician: ____

____

Adverse reactions for unauthorized users: ____

____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack:

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Other special instructions: ____

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PHYSICIAN AND PARENT/GUARDIAN NAMES, SIGNATURES AND EMERGENCY PHONE NUMBERS ARE REQUIRED

Physician name: ______________________________ Phone: ______________

Physician signature: ______________________________ Date: ______________

Parent/Guardian name: ______________________________ Phone: ______________

Parent/Guardian signature: ______________________________ Date: ______________